City of Long Beach
PREDESIGNATION OF PHYSICIAN FORM

Workers' Compensation Claims Office
(562) 570-2245 / (562) 570-2220 FAX

(**Please print clearly)**

To Be Completed By Employee

In the event of a work-related injury or illness, I request to be treated by my personal physician.
I understand this designation must be made prior to the date of injury.

The physician I selected meets the following criteria:

- Maintains a practice within a reasonable geographical area from my residence or work location.
- Is a licensed physician pursuant to Chapter 5 of Division 2 of the Business and Professions Code.
- Is my regular physician, who has limited his/her practice of medicine to general practice or who is a board-certified internist, pediatrician, or family practitioner.
- Retains my treatment records including my medical history.
- Agrees prior to the injury to be designated as my physician in the event an industrial injury occurs.

Both of the following sections must be completed and submitted to Workers' Compensation prior to any date of injury in order for this pre-designation to be valid.

Employee Name _____
Employee Social Security Number _____
Pre-designated Physician's Name _____
Physician's Address _____
Physician's Telephone Number **( )** _____

Employee Signature _____ **Date** _____

To Be Completed By Physician

PHYSICIAN'S AGREEMENT TO CRITERIA FOR PREDESIGNATION

1. I am a physician who is licensed pursuant to Chapter 5 of Division 2 of the Business and Professions Code.
2. I have previously directed medical treatment of the employee as his/her regular physician.
3. I retain the employee's medical treatment records, including his or her medical history.
4. I agree to treat this employee for a work-related injury.
5. I have signed this agreement prior to the employee sustaining an industrial injury.
6. I understand my reporting requirements outlined by Rules and Regulations 9785 through 9785.5.
7. I understand that per LC 4604.5 and LC 4610 my treatment requests will be reviewed through Utilization Review to determine medical necessity in accordance with the American College of Occupational and Environmental Medicine (ACOEM). Further, this guideline can be utilized to approve, modify, delay, or deny a medical treatment request.
8. I acknowledge the application of the Official Medical Fee Schedule to my charges relating to medical treatment for this work related injury.

I, _____, am a physician. I have read and certify that I meet, and will adhere to, the requirements listed above as the pre-designated personal physician for _____.
(Employee's Name)

Physician Signature _____ **Date** _____

Distribution: Workers' Compensation – original Employee's Department/Occupational Health/Employee – copies